Foster Family Home - Corrective Action Report

Provider ID:

1-100036

Home Name:

Ederlina Manzano, CNA

Review ID:

1-100036-7

1707 Kamehameha IV Road

Reviewer:

David Ayling

Honolulu

96819

Begin Date:

2/12/2020

Foster Family Home	Required Certificate	[11-800-6]
6.(d)(1) Comply	with all applicable requirements in this chapter, a	
6.(d)(1) - Home inspection with all items due to CTA	on for a 3 person CCFFH recertification. Cor by 3/12/20.	rective Action Report issued during home inspection
Foster Family Home	Personnel and Staffing	[11-800-41]
41.(b)(7) Have a	current tuberculosis clearance that meets departm	ent quidelines, and
41.(b)(8) Have do	cumentation of current training in blood borne pati ation, and basic first aid.	nogen and infection control, cardiopulmonary
41.(b)(7) - No current TB of 41.(b)(8) - No current CPR	clearance for CG #6 R and Basic First Aid for CG #6. Expired on 1/	7/19.

Foster Family Home

Records

[11-800-54]

54.(c)(2)

Client's current individual service plan, and when appropriate, a transportation plan approved by the department;

Comment:

54.(c)(2) - No Service Plan for Client #1 from CMA #1.

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2/13/2020 1:39 AM

Community Care Foster Family Home (CCFFH) Written Plan of Correction for Deficiencies Listed in Corrective Action Report

CCFFH Name: Ederlina Manzano

CCFFH Address: 1707 Kamehameha IV Road, Honolulu, HI 96819

Rule Number	Corrective Action Taken	Date Corrected	Prevention Strategy
41(b)(7) 41(b)(8)	I received current TB clearance, CPR and First Aid from CG #6.	02/17/2020	Home will put expiration dates for TB CPR, and First Aid on iPhone calendar. Will set reminders for one month prior to
54 (c)(2)	I reminded CMA #1 for a service plan for Client #1.	02/15/2020 RELETUED SERVEE PLAN 3/5/20	expiration. I will make sure CMA RN does a service plan every six months.

Primary Caregiver's Signature:

Print Name: East-lina Vianteno

Date of Signature: 2/17 /2020